SLEEP UNIT REQUEST FORM

Cromwell Hospital

Appointment telephone: +44 (0)20 7460 5836 **Fax:** +44 (0)20 7835 2430 **Email:** sleep.clinic@cromwellhospital.com

Patient details or sticker Name _____ DOB _____ MRN _____	Reason for sleep study prescription:

Current medications:

Allergies:

Infectious status:

☐ MRSA ☐ TB ☐ HIV

Sleep Investigations		
TOSCA01	Respiratory Study with CO2 Monitoring (for OSA & Hypoventilation) - Inpatient Only	
551925	Adult/Paediatric Nocturnal Polysomnography (NPSG)	
552027	Adult PSG with PAP Titration (Split Night)	CPAP/BiPAP
552027	Full night PAP Titration	CPAP/BiPAP
552028	Polysomnography and Multiple Latency Sleep Test	
558008	Home Video-Polysomnography	
558010	Home Video-Telemetry with Polygraphy	
551928	Maintenance Wakefulness Test	
150035	Ambulatory Overnight Oximetry (Portable Take-Home Sleep Monitor)	
420001	Actigraphy (14 day study)	
150006	Actigraphy Watch Hire (CHARGE)	
CPAP/NIV Prescriptions and Trials		
150045	CPAP Trial (2 week hire and home trial)	CPAP
150060	NIV Trial (2 week hire and home trial)	BiPAP
150004	CPAP Hire (CHARGE)	
DBX500H15	Dreamstation Auto with humidifier	
150050	CPAP/NIV Download and Follow-up	

Authorisation	
Requesting doctor	
Signature	
Date	

Return Report to (please complete 1 of the below)			
Fax (safe haven)		Email (emails to non-Cromwell accounts will be encripted)	
Name and address			